EXHIBIT “5”

IN THE UNITED STATES DISTRICT COURT FOR
THE NORTHERN DISTRICT OF ALABAMA
SOUTHERN DIVISION

ONIN STAFFING, LLC,	)	
	)	
Plaintiff,	)	
	)	
vs.	)	CIVIL ACTION NO.
	)	_____
PHILADELPHIA INDEMNITY INSURANCE COMPANY,	)	
	)	
	)	
Defendant.	)	

DECLARATION OF MICHAEL SISK

Michael Sisk hereby declares pursuant to 28 U.S.C. § 1746 that the following is true under penalty of perjury:

1. My name is Michael Sisk. I am over the age of nineteen (19) years and have personal knowledge of the matters stated herein.

2. I am the Vice President, Management & Professional Liability Underwriting of Philadelphia Indemnity Insurance Company. I have been employed with Philadelphia Indemnity Insurance Company since September 2007 and have held this position since January 2020. I am familiar with the corporate structure of the company and the application process for policies issued by the company. I am also familiar with the application for insurance submitted by Onin Staffing and the policy issued to Onin Staffing.

3. Philadelphia Indemnity Insurance Company is an insurance business corporation organized under the laws of the State of Pennsylvania with its principal place of business in the state of Pennsylvania.

4. Attached as Exhibit A to this Declaration is a true and correct copy of the application for insurance submitted by Onin Staffing on July 3, 2020.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

FURTHER DECLARANT SAITH NOT.

Executed on January 18, 2022.

DocuSigned by:
Michael Sisk
EB0AFAACA08B44A...

EXHIBIT "A"

PHILADELPHIA INSURANCE COMPANIES
A Member of the Tokio Marine Group

One Bala Plaza, Suite 100
Bala Cynwyd, PA 19004

RENEWAL APPLICATION FOR:

PRIVATE COMPANY PROTECTION PLUS
DIRECTORS AND OFFICERS & PRIVATE COMPANY LIABILITY INSURANCE
EMPLOYMENT PRACTICES LIABILITY INSURANCE
FIDUCIARY LIABILITY INSURANCE

NOTICE: THIS POLICY IS WRITTEN ON A CLAIMS MADE BASIS AND COVERS ONLY THOSE CLAIMS FIRST MADE DURING THE POLICY PERIOD AND REPORTED IN WRITING TO THE UNDERWRITER PURSUANT TO THE TERMS HEREIN. THIS POLICY PROVIDES A LIMIT OF LIABILITY AVAILABLE TO PAY JUDGMENTS OR SETTLEMENTS THAT SHALL BE REDUCED BY AMOUNTS INCURRED AS DEFENSE COSTS. FURTHER NOTE THAT DEFENSE COSTS PAID SHALL BE APPLIED AGAINST THE RETENTION AMOUNT.

INSTRUCTIONS

- Whenever used in this Application the term **Applicant** shall mean the Named Corporation and its wholly-owned/controlled Subsidiaries and their respective Directors, Officers, Trustees or Governors.
- The **Applicant** is required to complete Application Sections 1 and 5.
- The **Applicant** should complete the other applicable Section(s) for which coverage is desired. (See chart below)

Check Coverage Desired	Application Section	Requested Limit	Requested Retention	Requested Effective Date
General Information	1	N/A	N/A	N/A
☐ Directors & Officers	2	$	$	
☒ Employment Practices	3	$3,000,000	$	$50,000
☐ Fiduciary Liability	4	$	$	
General Summary	5	N/A	N/A	N/A

SECTION 1 – GENERAL INFORMATION

1. Name of **Applicant**: Onin Staffing
2. Change in Address: ☒None or _____
3. Change in website address: ☐None or www._____
4. Have there been any changes in the **Applicant's** operations? ☐Yes ☒No
   If yes, please provide details.

5. The Officer of the **Applicant** designated to receive any and all notices from the Underwriter or their authorized representative concerning this insurance is: Name: Christa Mrachkovskly

5A. Risk Management Contact: Christa Mrachkovskly Risk Management's Phone: 2052987233
Risk Management Email: Christam@oningroup.com

SECTION II - DIRECTORS & OFFICERS INFORMATION

(Complete this section **only** if Directors & Officers Liability coverage is desired.)

6. **Ownership Information:**
   a. Number of common shares outstanding: _____ If LLC, number of membership shares: Split 33.3%
   b. Number of common shareholders: 3 Number of active members: 3
   c. Total number of shares owned directly or beneficially by Directors & Officers or Board of Managers: _____
   d. Does any shareholder(s) or group of affiliated shareholders (including an employee stock ownership plan) own more than five (5)% of the voting shares directly or beneficially? ☐ Yes ☐ No
      If yes, please provide details.

   e. Are there any changes in ownership from the prior year? ☐ Yes ☒ No
      If yes, please provide details.

7. Provide a list of all direct and indirect subsidiaries.
   Name: _____ Type of Business: _____
   Percent owned by the Applicant: _____ % Date Created/Acquired: _____

   Name: _____ Type of Business: _____
   Percent owned by the Applicant: _____ % Date Created/Acquired: _____

   Name: _____ Type of Business: _____
   Percent owned by the Applicant: _____ % Date Created/Acquired: _____
   If additional space is needed, please attach a separate page or use the additional information page provided at the end of the application.

8. In the past twelve (12) months, does the **Applicant** anticipate being involved in any of the following: **If yes, provide details by attachment.**
   Merger, acquisition or consolidation with another entity? ☐ Yes ☒ No
   Sales, distribution or divestiture of any assets other than in the ordinary course of business? ☐ Yes ☒ No
   Changes in the board of directors or senior management (other than death or retirement)? ☐ Yes ☒ No
   Change in the **Applicant's** independent auditors? ☐ Yes ☒ No

9. **Offering of Securities Information**
   a. Within the next twelve (12) months is the **Applicant** contemplating any private offering of debt or equity of securities? ☐ Yes ☒ No
      If yes, please attach the offering memorandum or prospectus describing the essential terms of each transaction, including the effective date, the professionals used, the amount of the offering and the current status of each such transaction.

10. **Financial Information**
    a. Within the next twelve (12) months, is the **Applicant** contemplating any bankruptcy, reorganization or arrangement with creditors under federal or state law? ☐ Yes ☒ No
    b. Is the **Applicant** in violation of any of its debts or loan convenants? ☐ Yes ☒ No

c. In the past twelve (12) months, did an Independent CPA render a "going concern" opinion? ☐ Yes ☒ No

Note: If the Applicant answered yes to 10 (a), (b), or (c) please attach details including the most recent financial audit, review or compilation with the auditors notes.

11. **Outside Directorship**

Does the **Applicant** direct or request any individual to serve as director, officer, governor or trustee of any other entity? NO

If yes, please complete questions a – g below.

a. Name of individual director, officer, governor or trustee:_____ Position held:_____

b. Name of outside entity:_____

c. Nature of entity's business:_____

d. Percentage of ownership by **Applicant**: _____% Domestic or Foreign:_____

e. Does the outside entity provide indemnification to its Directors and Officers? ☐ Yes ☐ No

f. Complete the following information regarding the Directors and Officers Liability Insurance carried by the outside entity: Insurer:_____ Limit of Liability: $_____ Policy Period:_____

g. Has the outside entity or its Directors and Officers been involved in any Directors and Officers Liability litigation? ☐ Yes ☐ No

SECTION III - EMPLOYMENT PRACTICES INFORMATION

(Complete this section **only** if Employment Practices Liability coverage is desired.)

12. Please provide the following employee count information:

	Currently	One Year Ago	Two Years Ago
U.S. based employees:			
Total Full Time:	439	560	
Total Part Time:			
Volunteers:	10		
Temporary:	8		
Leased:			
Total Non U.S. based employees:	9,430	10,825	
TOTAL SUM OF ABOVE:	0		
	9,879		

Number of employees per the following states:

CA:	60		
FL:	87		
NJ:	11		
NY:	15		
TX:	148		

13. Total number of current employees with annual compensation greater than $100,000: 53

14. How many employees have been terminated or demoted in the past twelve (12) months?

Voluntary: 4,232 Involuntary: 5,060 Laid Off: 2,484

15. Is any reduction of employees or change of status anticipated or being contemplated in the next year? ☐ Yes ☒ No

If yes, number estimated:_____

16. Does the **Applicant** anticipate any plant, facility, branch, office, or department closing, consolidation, reorganization or layoff in the next twelve (12) months? ☐ Yes ☒ No

If yes, provide details.

17. Does the **Applicant** have a human resources department? ☒ Yes ☐ No
If no, describe how this function is handled.

18. **Human Resource Policies and Procedures**
Has the **Applicant** implemented any new employment policies or procedures over the past twelve (12) months? ☐ Yes ☒ No
If yes, please provide details.

SECTION IV - FIDUCIARY LIABILITY COVERAGE

(Complete this section **only** if Fiduciary Liability coverage is desired.)

19. List all plans for which coverage is requested (use attachment if necessary):

	Plan Name	Year Established	Assets/ Contributions	Type*	Participants	Administrator
	Example: The ABC Manufacturing Corp 401K Plan	2000	$1,000,000	3	75	self
a)	Onin Group 401K plan	2004	$ 4,139,371	2	599	Self (Onin Group)
b)			$			
c)			$			
d)			$			

* 1 = Employee Welfare Benefit Plan (as defined by ERISA)
2 = Defined Contribution Plan (as defined by ERISA)
3 = Defined Benefit Plan (as defined by ERISA)
4 = Other **If "Type" is an ESOP a Fiduciary Liability - ESOP Supplement must be completed.**

If additional space is needed, please attach a separate page or use the additional information page provided at the end of the application.

20. Have there been any changes to any plan listed above? ☐ Yes ☑ No
If yes, provide details by attachment.

21. Has any plan requested or contemplated filing a request for termination? ☐ Yes ☑ No
If yes, provide details by attachment.

22. Has any plan been spun-off (sold), transferred or terminated? ☐ Yes ☑ No
If yes, provide details by attachment.

Please attach the most recent tax form 5500 for each plan listed above.

SECTION V- GENERAL SUMMARY
(The Applicant must complete this section.)

23. Please provide details on the following insurance coverage currently in place:

COVERAGES	Insurance Company	Limit of Liability	Deductible	Policy Effective Dates
General Liability				
Professional Liability				

24. Has the **Applicant** been the subject or involved in any litigation in the past twelve (12) months? ☐ Yes ☒ No
If yes, provide details by attachment.

25. In the next twelve (12) months, does the **Applicant** anticipate any substantial change or reorganization of operations? ☐ Yes ☒ No
If yes, provide details by attachment.

Material Change
If there is any material change to the answers of this Application's questions prior to the policy inception date, the Applicant must notify the Underwriter in writing. Any outstanding quotation may be modified or withdrawn.

False Information

FRAUD STATEMENT AND SIGNATURE SECTIONS

The Undersigned states that he/she is an authorized representative of the Applicant and declares to the best of his/her knowledge and belief and after reasonable inquiry, that the statements set forth in this Application (and any attachments submitted with this Application) are true and complete and may be relied upon by Company * in quoting and issuing the policy. If any of the information in this Application changes prior to the effective date of the policy, the Applicant will notify the Company of such changes and the Company may modify or withdraw the quote or binder.

The signing of this Application does not bind the Company to offer, or the Applicant to purchase the policy.
***Company refers collectively to Philadelphia Indemnity Insurance Company and Tokio Marine Specialty Insurance Company.**

FRAUD NOTICE STATEMENTS

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS THAT PERSON TO CRIMINAL AND CIVIL PENALTIES (IN OREGON, THE AFOREMENTIONED ACTIONS MAY CONSTITUTE A FRAUDULENT INSURANCE ACT WHICH MAY BE A CRIME AND MAY SUBJECT THE PERSON TO PENALTIES). (IN NEW YORK, THE CIVIL PENALTY IS NOT TO EXCEED FIVE THOUSAND DOLLARS ($5,000) AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION). **(NOT APPLICABLE IN AL, AR, AZ, CO, DC, FL, KS, LA, ME, MD, MN, NM, OK, PA, RI, TN, VA, VT, WA AND WV).**

APPLICABLE IN AL, AR, AZ, DC, LA, MD, NM, RI AND WV: ANY PERSON WHO KNOWINGLY (OR WILLFULLY IN MD) PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY (OR WILLFULLY IN MD) PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES OR CONFINEMENT IN PRISON.

APPLICABLE IN COLORADO: IT IS UNLAWFUL TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, DENIAL OF INSURANCE AND CIVIL DAMAGES. ANY INSURANCE COMPANY OR AGENT OF AN INSURANCE COMPANY WHO KNOWINGLY PROVIDES FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO A POLICYHOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICYHOLDER OR CLAIMANT WITH REGARD TO A SETTLEMENT OR AWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AGENCIES.

APPLICABLE IN FLORIDA AND OKLAHOMA: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A FELONY (IN FL, A PERSON IS GUILTY OF A FELONY OF THE THIRD DEGREE).

APPLICABLE IN KANSAS: AN ACT COMMITTED BY ANY PERSON WHO, KNOWINGLY AND WITH INTENT TO DEFRAUD, PRESENTS, CAUSES TO BE PRESENTED OR PREPARES WITH KNOWLEDGE OR BELIEF THAT IT WILL BE PRESENTED TO OR BY AN INSURER, PURPORTED INSURER, BROKER OR ANY AGENT THEREOF, ANY WRITTEN, ELECTRONIC, ELECTRONIC IMPULSE, FACSIMILE, MAGNETIC, ORAL, OR TELEPHONIC COMMUNICATION OR STATEMENT AS PART OF, OR IN SUPPORT OF, AN APPLICATION FOR THE ISSUANCE OF, OR THE RATING OF AN INSURANCE POLICY FOR PERSONAL OR COMMERCIAL INSURANCE, OR A CLAIM FOR PAYMENT OR OTHER BENEFIT PURSUANT TO AN INSURANCE POLICY FOR COMMERCIAL OR PERSONAL INSURANCE WHICH SUCH PERSON KNOWS TO CONTAIN MATERIALLY FALSE INFORMATION CONCERNING ANY FACT MATERIAL THERETO; OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO.

APPLICABLE IN KENTUCKY: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSONS FILES AN APPLICATION FOR INSURANCE CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

APPLICABLE IN MAINE, TENNESSEE, VIRGINIA AND WASHINGTON: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES OR A DENIAL OF INSURANCE BENEFITS.

APPLICABLE IN PENNSYLVANIA: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

APPLICABLE IN NEW YORK: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SHALL BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATE VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

Christa MrachKovskiy
NAME (PLEASE PRINT/TYPE)

Director of Risk & Safety
TITLE

(MUST BE SIGNED BY THE PRESIDENT, CHAIRMAN, CEO OR EXECUTIVE DIRECTOR)

SIGNATURE

7/3/2020
DATE

SECTION TO BE COMPLETED BY THE PRODUCER/BROKER/AGENT

PRODUCER
(If this is a Florida Risk, Producer means Florida Licensed Agent)

AGENCY

PRODUCER LICENSE NUMBER
(If this a Florida Risk, Producer means Florida Licensed Agent)

ADDRESS (STREET, CITY, STATE, ZIP)

As part of this Application, please submit the following documents:

a) **Applicant's latest fiscal year end financial statement (CPA prepared) and latest interim financial statement**
b) List of the **Applicant's** current Directors & Officers
c) Copies of the most recently filed Form(s) 5500 (and attachments) for all ERISA plans for which coverage requested (If Fiduciary Liability coverage is being requested)

THE INFORMATION CONTAINED IN AND SUBMITTED WITH THIS APPLICATION IS ON FILE WITH THE UNDERWRITER AND ALONG WITH THE APPLICATION IS CONSIDERED PHYSICALLY ATTACHED TO AND PART OF THE POLICY, SHOULD ONE BE ISSUED. THE UNDERWRITER WILL HAVE RELIED UPON THIS APPLICATION AND ATTACHMENTS IN ISSUING ANY POLICY.

Form 5500

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code).

▶ Complete all entries in accordance with the instructions to the Form 5500.

OMB Nos. 1210-0110
1210-0089

2019

This Form Is Open to Public Inspection

Part I Annual Report Identification Information

For calendar plan year 2019 or fiscal plan year beginning 01/01/2019 and ending 12/31/2019

A This return/report is for: ☐ a multiemployer plan ☐ a multiple-employer plan (Filers checking this box must attach a list of participating employer information in accordance with the form instructions.)
☒ a single-employer plan ☐ a DFE (specify) ___

B This return/report is: ☐ the first return/report ☐ the final return/report
☐ an amended return/report ☐ a short plan year return/report (less than 12 months)

C If the plan is a collectively-bargained plan, check here. . . . . ▶ ☐

D Check box if filing under: ☒ Form 5558 ☐ automatic extension ☐ the DFVC program
☐ special extension (enter description)

Part II Basic Plan Information—enter all requested information

1a Name of plan
ONIN GROUP 401(K) PLAN

1b Three-digit plan number (PN) ▶ 001

1c Effective date of plan 10/01/2004

2a Plan sponsor's name (employer, if for a single-employer plan)
Mailing address (include room, apt., suite no. and street, or P.O. Box)
City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions)
ONIN STAFFING LLC

1 PERIMETER PARK SOUTH SUITE 450N

BIRMINGHAM AL 35243

2b Employer Identification Number (EIN) 63-1180986

2c Plan Sponsor's telephone number 205-298-7233

2d Business code (see instructions) 561300

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.

SIGN HERE	Signature of plan administrator	Date 7/2/20	ERIN M HERRERA Enter name of individual signing as plan administrator
SIGN HERE	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE	Signature of DFE	Date	Enter name of individual signing as DFE

For Paperwork Reduction Act Notice, see the Instructions for Form 5500.

Form 5500 (2019)
v. 190130

3a Plan administrator's name and address [X] Same as Plan Sponsor	3b Administrator's EIN	
	3c Administrator's telephone number	
4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report: a Sponsor's name c Plan Name	4b EIN 4d PN	
5 Total number of participants at the beginning of the plan year	5	468
6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1), 6a(2), 6b, 6c, and 6d).		
a(1) Total number of active participants at the beginning of the plan year	6a(1)	355
a(2) Total number of active participants at the end of the plan year	6a(2)	374
b Retired or separated participants receiving benefits	6b	10
c Other retired or separated participants entitled to future benefits	6c	176
d Subtotal. Add lines 6a(2), 6b, and 6c	6d	560
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	6e	0
f Total. Add lines 6d and 6e	6f	560
g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	6g	532
h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested	6h	94
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	7	

8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions:
2E 2F 2G 2J 2K 2S 2T 3D 3H

b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions:

9a Plan funding arrangement (check all that apply)	9b Plan benefit arrangement (check all that apply)
(1) [X] Insurance	(1) [X] Insurance
(2) [ ] Code section 412(e)(3) insurance contracts	(2) [ ] Code section 412(e)(3) insurance contracts
(3) [ ] Trust	(3) [ ] Trust
(4) [ ] General assets of the sponsor	(4) [ ] General assets of the sponsor

10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)

a Pension Schedules

(1) [X] R (Retirement Plan Information)

(2) [ ] MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary

(3) [ ] SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary

b General Schedules

(1) [X] H (Financial Information)

(2) [ ] I (Financial Information – Small Plan)

(3) [X] 1 A (Insurance Information)

(4) [X] C (Service Provider Information)

(5) [X] D (DFE/Participating Plan Information)

(6) [ ] G (Financial Transaction Schedules)

Part III Form M-1 Compliance Information (to be completed by welfare benefit plans)

11a If the plan provides welfare benefits, was the plan subject to the Form M-1 filing requirements during the plan year? (See instructions and 29 CFR 2520.101-2.) ☐ Yes ☐ No

If "Yes" is checked, complete lines 11b and 11c.

11b Is the plan currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520.101-2.) ☐ Yes ☐ No

11c Enter the Receipt Confirmation Code for the 2018 Form M-1 annual report. If the plan was not required to file the 2018 Form M-1 annual report, enter the Receipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)

Receipt Confirmation Code_____

ADDITIONAL INFORMATION

This page may be used to provide additional information to any question on this application. Please identify the question number to which you are referring.

Signature

Date 7/3/20